SSQH-CS RBF Implementation Plan

Contents

Background

To strengthen the delivery of health services, the Ministère de Santé Publique et de la Population (MSPP), in partnership with the World Bank and USAID designed a National Results-Based Financing (RBF) program in 2011. The national RBF scheme builds on the pilot program implemented by the USAID funded Santé pour le Development et la Stabilité d'Haiti (SDSH II) project and is modeled after the Burundi and Rwanda RBF schemes. Under the Service de Santé de Qualité pour Haiti Central-South (SSQH-CS) project, USAID will implement the national RBF scheme in selected health facilities in central and south regions. There are, however, several important financing and implementation factors that need to be considered before the roll-out begins.

Key challenges include:

1. Given current funding, SSQH-CS cannot support the addition of RBF payments and continue to fully fund operation costs at the current level of funding.
2. SSQH-CS is currently unable to implement the subcontracting mechanism called for in the MSPP's RBF manual with publically-managed facilities at it is in violation of the SSQH-CS contract clause stating "Contractors shall not enter into direct subcontracting relationships with GOH entities or directly pay the salaries of GOH civil servants" (AID-521-C-13-00011, pg. 10).

To address these challenges, SSQH-CS developed concept notes that outlined financing and implementation options for MSPP and USAID to consider. (Please see Annex A for a full copy of the concept note.) In addition, RBF experts from USAID, LMG, SSQH-North, and SSQH- CS participated in a two-day workshop to discuss the various options outlined in the concept note.

The following implementation and financing plan is based on a review of the concept notes, as well as discussions and recommendations from the two-day RBF workshop. The objective of this memo is to outline concrete next steps that will guide the phased roll-out of RBF scheme in selected SSQH sites from 2014 to 2016.

RBF Funding

SSQH-CS will implement the full complement of the MSPP's RBF indicators at the recommended unit-price, as prescribed in the RBF manual. In order to provide the necessary funding to support RBF contracts, SSQH-CS will implement a 10% reduction in the operating budgets of all 80 SSQH-CS supported facilities. To note, this reduction is taking place in tandem with overall reductions in service delivery budgets; the total reduction a site could absorb will likely range from 12 to 20 percent. These reductions, in addition to cost reductions made by the project in the process of the year 2 work planning will enable the project to implement RBF in at least 30 facilities over the life of the project.

Table 1 provides an overview of estimated cost-savings from a 10% reduction of operations budget at all sites, and estimated RBF payment for 30 sites. For more information on the financial analysis used to determine the number of sites SSQH may support, please see Annex B.

Table 1: RBF Budget and Needed Reductions 2014 - 2016

2014 – 2016 RBF Budget			
Number of Sites	**Estimated RBF Budget for 30 sites**	**% Reduction of Operating Budgets from all SSQH –CS sites**	**Total Savings from 10% reduction**
80 Sites	---	10%	$ 1,525,152.50
30 RBF sites	$ 1,480,909.03	---	---

SSQH-CS will re-evaluate the RBF budget after 6 and 12 months to determine the impact of the budget reductions on the performance on all sites and if RBF can be implemented in additional sites.

Potential Impact of Budget Reductions

While reductions in operating budgets are necessary in order for SSQH-CS to be able to implement RBF, potential impact to health facilities should be considered. They may include reduction in number of staff, salaries, community mobilization services, mobile clinics, and ability to respond to stock outs. In turn, these reductions will likely affect overall quality of services and ability of health facilities to manage overall operations. In particular:

- Staff: Reductions in staff may result in decreased capacity to offer services and a decrease quality in services offered. Many facilities may cut outreach staff in an attempt to maintain facility based services.
- Salaries: Reduction in salaries of staff may result in high turn-overs among technical staff, or demoralization of staff resulting in a decrease in quality of services offered.
- Community mobilization activities: A reduction in community mobilization activities may result in a decrease in utilization of services.
- Mobile clinics: Facilities may reduce mobile services. This is of particular concern in difficult to reach areas where mobile clinic is a critical form of service delivery.

Finally, at this level of reduction, it may be challenging for certain sites to achieve the expected project results of increase service utilization and quality of care. In particular, a majority of sites would face a reduction in their operational budget without an opportunity to increase revenue through the RBF scheme.

SSQH-CS will monitor these potential impacts closely and re-evaluate funding levels for sites after 6 and 12 months of implementation.

Family Planning Indicator:

In order to be compliant with the Tiahrt Amendment, SSQH-CS will implement the MSPP's recommended family planning (FP) indicator but according to the Tiahrt Amendment we will need to rephrase this indicator in coordination with the MSPP and USAID.

Timeline

In coordination with MSPP, SSQH –CS developed a phased approach to implement RBF. In Phase 1 of RBF implementation, SSQH-CS will implement RBF in selected sites in Grand Anse and Nippes. In Phase 2 of the implementation, the team will expand RBF scheme to selected sites in the remaining departments. Please note that RBF expansion to Center and South Department will depend on the design of the RBF Impact Evaluation. SSQH-CS will continue to work closely with the World Bank and partners to finalize site selection in these two departments.

Table 2: Estimated Timeline for RBF Scale-up Per Department

Department	Oct. 2014 – Mar. 2015	April – Sept. 2015	Oct. 2015 – Mar. 2016	April – Sept. 2016
Nippes	X	X	X	X
Grand Anse	X	X	X	X
Sud			X	X
Centre			X	X
Ouest		X	X	X
Sud-Est		X	X	X

Mechanism for RBF Payments to Zone Cibles:

In order to find a solution to the challenge of making RBF payments to the Zone Cibles, SSQH-CS evaluated the following options:

> **Option 1:** Working within the current MoU framework under which the project supports Zone Cibles operating budgets
>
> **Option 2**: Fixed obligation grants
>
> **Option 3:** Direct sub-contracting with the Zone Cibles

For detail description of the options, please see Annex C.

SSQH-CS proposes a blended approach utilizing Options 1 and 3.

In order to allow the project to begin RBF while the contract modification is underway SSQH-CS will utilize the existing MOU payment mechanism to disburse RBF incentives (option 1). This will allow enrollment of ZC sites in Phase 1 of the RBF implementation.

Simultaneously, the team will move forward with operationalization of option 3: direct sub-contracting with Zone Cibles. In order to process RBF payments directly to ZC facilities, a modification to the SSQH contract clause stating “Contractors shall not enter into direct subcontracting relationships with GOH entities or directly pay the salaries of GOH civil servants” (AID-521-C-13-00011, pg. 10) will be required.

Support Needed from USAID:

To move forward with the implementation plan outlined in this memo, SSQH will need support from USAID on the following:

1. Approval of the implementation plan
2. Communication with MSPP on the proposed implementation plan
   In particular: Set up meeting between SSQH, USAID and MSPP to discuss RBF payments for zone cibles
3. Contract modification to allow direct payments to GOH entities

Annex A: RBF Program Financing and Implementation Approach

Overview and objective of the concept note

To strengthen the delivery of health services, the Ministère de Santé Publique et de la Population (MSPP), in partnership with the World Bank and USAID designed a National Results-Based Financing (RBF) program in 2011. The national scheme builds on the pilot program implemented by the USAID-funded Santé pour le Development et la Stabilité d'Haiti (SDSH II) project and is modeled after the Burundi and Rwanda RBF schemes. Under the Service de Santé de Qualité pour Haiti (SSQH) project, USAID will implement the MSPP-designed national scheme throughout the country. There are, however, several important contextual and design factors that need to be considered before the national roll-out begins.

The purpose of the concept note is to outline key design and implementation issues particular to the Haiti context and service delivery structure, and to provide financing and implementation options for MSPP and USAID to consider.

RBF Design: Operation cost vs. RBF Incentive

Results based financing is a broad term that covers a number of approaches to reward the provision of more and better health care services. However, the design, scope, and types of incentives vary broadly, from country to country. On one end of the spectrum, RBF financing represents a complete shift in purchasing – from a more traditional budget system where hospitals and clinics are given block grants regardless of performance, to a 'fee-for-service' payment structure with very little to no additional funding given to support the operation of the clinics. Revenue collected from the 'fee-for-service' design is intended to cover all operation costs and the health facility is financially self-sufficient. In this arrangement, health facilities bear the majority of the risks of poor performance and the payer is protected from potential ineffective and inefficient use of funds. On the other end of the spectrum, RBF incentives are bonus payments made on top of operation budgets designed to motivate improvements in service delivery. In this model, health facilities continue to receive public funding that finances day-to-day operations and are eligible to receive additional incentive payments when targets are reached. In this structure, the health facilities are exposed to less financial risk, as performance does not affect coverage of operation costs but influences incentive eligibility only. This model requires full financing of health services – both operational costs and RBF incentives – by parties external to the health facility.

While the 'fee-for-service' or some form of capitation payment model is common in middle and higher income countries, a majority of developing countries, including Burundi, Rwanda, Zambia and Afghanistan, employ the later type of incentive structure as the health facilities do not have the ability to fully cover operating costs from RBF incentives.

It should be noted that there is no 'right' model for a country. Rather, the design is dependent on a number of factors including the overall objective of the scheme, the country context, and the structure of health financing in the country. For instance, in Rwanda and Burundi, a majority of the operating costs are borne by the government, and RBF incentives are financed by implementing partners including USAID, the World Bank, and the Global Fund.

Table 1 provides an overview of the different models and example of countries that have adopted these models.

Table 1: RBF models in Rwanda, Burundi and Haiti (MSH)

	Model	Operation Cost	RBF Incentive
Rwanda	Scheme provides incentive payments on 22 quantity indicators. Final payment is dependent on score on the quality index	~ 100% paid for by government	RBF incentives, financed by development partners are provided in addition to operating cost
Burundi	Scheme covers 40 primary healthcare facilities. Facilities received a fixed amount per targeted action plus a bonus of up to 15 per cent for quality	~ 100% paid for by government	RBF incentives, financed by development partners are provided in addition to operating cost
Haiti (MSH Pilot)	5 – 6 quantity and quality indicators selected at random (out of a list of 14 indicators) Facility eligible to earn up to 10% additional financing if targets are met	95% paid for by USAID	Up to 10% additional payment financed by USAID

Evolution of the RBF system in Haiti and Key Issues to Consider

In 1999, Management Sciences for Health (MSH) introduced features of RBF scheme in three NGO-managed health facilities. Preliminary assessment showed substantial improvements in service utilization among the intervention sites, and the pilot scheme was scaled to all NGO facilities in 2005. At the end of the project SDSH included the both ZC and NGO supported facilities. Key elements of the pilot scheme include:

Implementing partner disbursed 95% of budgeted funding to health facilities on a quarterly basis, and health facilities are eligible to receive up to 10% of additional funding through RBF.

- MSH randomly selects 5 – 6 indicators (out of a list of 14 indicators) to assess on a quarterly basis. Payments are made based on 'targets' reached, rather than unit price.

In 2011, MSPP re-designed the RBF program and changed several important features including:

- RBF financial incentives will be largely driven by unit-price per indicator. In addition, health facilities are eligible to make up to an additional 25% of the total incentive amount based on quality of services.
- A list of 17 quantity indicators are pre-defined for dispensaries, CSLs and CALs plus 5 more indicators for referral hospitals (HCR); quality is assessed via scores from a quality grid of around 200 indicators.

  The SSQH-CS team in consultation with MSPP team has developed a two tier program. The first tier

- No clear guidelines on payment of operating cost. The MSPP RBF manual does not provide guidance on how health facility operation costs should be covered and by whom; nor does it specify for implementing partners already financing service delivery how they should balance the cost of operations with incentive payments at the facility level. This leaves open options to either continue fully funding operating costs or reduce operating cost subsidies and shift some of the risk to facilities by making RBF incentives necessary to fully cover the cost of operation. It should be noted that the World Bank RBF payments are only for RBF incentives and does not include operating costs.

Implications to SSQH program roll-out and sustainability of the program

Based on preliminary analysis, proportion of the overall budget represented by RBF incentive payment (should the health facility achieve coverage as predicted in the model) ranges from 1% of operating cost for HCR to as high as 38% of operating cost for health facilities.

Table 2: Annual Operations versus RBF Incentive Budget Totals

Department	Operation Costs in USD for 12-month Period (all SSQH-CS facilities)	RBF Incentive Costs in USD for 12-month Period (all SSQH-CS facilities)*
Grand Anse	$1,449,122	$221,668
Nippes	$1,316,668	$88,477
Centre	$849,557	$184,029
Ouest	$3,608,992	$1,861,494
Sud	$855,955	$99,666
Sud-est	$320,190	$88,604
Total	**$8,400,484**	**$2,543,938**

* RBF incentive budget are based on coverage estimates provided by MSPP in the RBF Budget Template.

Given current funding, SSQH cannot support the addition of RBF payments and continue to fully fund operation costs at the current level of funding.

The scenarios below detail options for shifting costs in order to make funds available for RBF.

Scenarios for Introducing RBF at Project-supported Sites

Given the stark funding gap between the operational costs of service delivery and the potential incentive-earning under the RBF model, SSQH-CS presents three scenarios for consideration for how the project could feasibly roll-out RBF in its catchment area.

The variables we considered to help balance cost constraints while still proposing a reasonable roll-out plan included a review of:

1) Coverage of RBF within each department (i.e., implementing RBF in all SSQH-CS facilities within the Department vs. selecting facilities within each Department to participate in the RBF scheme), and
2) The timing of scale-up efforts. All scenarios start with introducing RBF in Nippes and Grand Anse departments, per MSPP request (made during meeting on July 14, 2014), and expand next to Sud and Centre departments (following completion of the World Bank Impact Evaluation study), and finally to Ouest and Sud-Est departments. The speed at which this scale up happens will depend upon the coverage of RBF within each department and the funds available for RBF based on how the project shifts costs.

For all three scenarios outlined below, the general orientation to scale-up is consistent: RBF implementation will focus exclusively on Nippes and Grand Anse October 2014 – March 2015. During this time, the project will provide RBF-readiness support and trainings in selected facilities (exact number TBD, depending on financing scenario selected) in Sud and Centre. RBF scale up to these departments will follow the completion of the World Bank Impact Evaluation study in April 2015. Starting in October 2015 the project will provide RBF-readiness support and trainings in selected facilities (exact number TBD, depending on scenario selected) in Ouest, and Sud-Est departments with the aim for qualified facilities in these two departments to start RBF implementation by December 2015.

<u>The exact number of facilities to implement RBF in Sud, Centre, Ouest, and Sud-Est will depend upon the scenario selected and cost analyses.</u>

Table 3: Scenario Timeline for RBF Scale-up Per Department

Department	Oct. 2014 – Mar. 2015	April – Sept. 2014	Oct. 2015 – Mar. 2016	April – Sept. 2016
Nippes	X	X	X	X
Grand Anse	X	X	X	X
Sud		X	X	X
Centre		X	X	X
Ouest			X	X
Sud-Est			X	X

Scenario 1

Scenario 1 focuses on employing the full list of RBF quantitative and qualitative indicators at each service delivery tier[1]. Scenario 1 strives to bring all SSQH facilities within Nippes & Grand Anse (15) onto

[1] SSQH-CS will implement 16 of the 17 indicators as the 17th indicator would contravene Tiahrt regulations

the RBF model by end of December 2014. RBF preparations and trainings in these departments will begin in August 2014.

In order to support the funding for RBF incentives scenario one would require a reduction to each facility's operational budget. In an effort to standardize budget cuts fairly across facilities (while not being overly prescriptive and burdensome), this scenario establishes two budget "floors" per level of service tier. On the other end of the scale, budget "ceilings" (operational + total RBF costs) help cap potential RBF payments across service tiers so as to incentivize at a consistent rate among similar facilities. Table 4 illustrates the two tier payment structure for Grand Anse and Nippes for the first year of RBF implementation based upon a cost analysis. RBF implementation October 2015 – September 2016 will have different payment spreads, further decreasing the operations budget while raising the potential for RBF incentives.

Scenario 1: Key Design Element

Package: 16 quantitative indicators (excluding FP indicator per discussion with USAID) at full unit price and list of qualitative indicators, adjusted for services offered at level of care.

Incentive Payment Structure:
For Disp, CSL & CAL:
- SSQH provides 90% operational cost
- Facilities have opportunity to earn up to 15% additional funding from RBF incentives (total 105%)

For Referrals and Hospitals:
- SSQH provides 100% of operational cost
- HCRs have opportunity to earn up to 1% additional funding from RBF incentives (total 101%)

Scenario 1 RBF Year 1 (October 2014 – September 2015) for Nippes & Grand Anse

- Tier 1 (Dispensary, CSL & CAL): 90% operational budget / up to 105% operational budget + RBF
- Tier 2 (Referral Hospitals/HCRs): 100% operational budget / up to 101% operational budget + RBF

Table 4: Scenario 1 - Minimum and Maximum Budgets per Facility in Grande Anse and Nippes

Facility	ZC/NGO	Primary Service Tier	1 Year's Operating expenses (in USD)	Minimum - Year 1*	Maximum - Year 1**
Grande Anse					
DDS Operating Cost			357,131.15	357,131.15	357,131.15
CS Abricots	Abricots	CSL	109,226.45	98,303.80	114,687.77
CS de Corail	Corail	CSL	83,997.34	75,597.60	88,197.20
Klinik Pèp Bondye	HHF	Dispensaire	396,631.26	356,968.14	416,462.83
Klinik St. Joseph	HHF	Dispensaire	72,965.12	65,668.60	76,613.37
CSSH	CSSH	CAL	105,825.34	95,242.81	111,116.61
CS Léon Coicou	CSLC	CAL	53,065.13	47,758.61	55,718.38
AEADMA, Dame Marie	AEADMA	HCR	270,280.61	270,280.61	272,983.42
Sub-total			**1,449,122.40**	**1,366,951.33**	**1,492,910.73**
Nippes					

DDS Operating			510,246.58	510,246.58	510,246.58
CS de L'Azile	L'Azile	CAL			
Disp. Changieux	L'Azile	Dispensaire			
Disp Morisseau	L'Azile	Dispensaire			
L'Azile Total			281,579.45	253,421.51	295,658.42
CS Petit Trou de Nippes	Petit Trou de Nippes	CAL			
Disp Grand Boucan	Petit Trou de Nippes	Dispensaire			
Petit Trou de Nippes Total			281,579.45	253,421.51	295,658.42
CS Jules Fleury	Anse a Veau	CAL			
Disp. Arnaud	Anse a Veau	Dispensaire			
Disp St. Yves	Anse a Veau	Dispensaire			
Total Anse a Veau			243,262.42	218,936.17	255,425.54
Sub-total			**1,316,667.90**	**1,236,025.77**	**1,356,988.97**

* Assumes 90% operating cost and 0% RBF incentive for Tier 1 facilities, and 100% operating cost and 0% RBF incentive for Tier 2 facilities
* Assumes 90% operating cost, and up to 15% additional payments as RBF incentives (total 105%) for Tier 1 facilities and 100% operating cost and up to 1% additional payments as RBF incentive (total 101%) for Tier 2 facilities.

The number of facilities to roll out RBF in the other four departments will be based upon further cost analyses. To the extent possible, payment structure will be consistent across six departments. However, the number of health facilities to be included in the RBF scheme within each Department will vary.

Contractual Arrangements: Agreements with NGO and publically-managed facilities will run for six months each with an option to renew. By October 2015, veteran facilities with these mechanisms will run for a full 12 months, while new facilities will start on a 6-month mechanism with an option to renew. Agreements will begin with a six month period to allow the project to evaluate facility performance and adjust budget floors and ceilings if appropriate. Technical assistance and CQI plans for facilities implementing RBF will emphasize strengthening quality and use of RBF management tools (Periodic Action Plans, monthly statistical reports [SIS], audit minutes and findings, and evaluation reports).

Scenario 1 Issues:

- Lower performing health facilities may not be able to earn enough from RBF incentive to cover operating costs; and
- Larger financial cost of RBF implementation will result in fewer facilities in Sud, Centre, Ouest, and Sud-Est implementing RBF.

Scenario 2

In scenario 2, salaries for the public facilities would be assumed by the MSPP. If the MSPP can support salaries for the public sites, reductions in the operation budgets for each facility to free funds for RBF payments will be smaller. The purpose in transferring salaries for the staff to MSPP is 1) to reduce the potential impact of the operational budget reductions on each facility, and 2) to enable the project to roll out RBF in a faster and more comprehensive manner.

Similar to the phased approach described in Scenario 1, SSQH –CS will begin RBF implementation in Nippes and Grand Anse, and expand to Sud, Center, Quest, and Sud-Est in subsequent years. The exact number of health facilities to be included in Sud, Center, Quest, and Sud-Est will depend on cost analysis.

Scenario 2: Key Design Element

Package: 16 quantitative indicators (excluding FP indicator per discussion with USAID) at full unit price and list of qualitative indicators, adjusted for services offered at level of care.

Incentive Payment Structure

- Transition salary payment for public facilities to MSPP
- SSQH continues to provide 1) full operational cost for NGOs and 2) operational cost minus salary for ZC facilities
- Facilities eligible for up to 10% in RBF incentives (110% total operation cost)

Table 5: Total Operating Expenses versus Total Salary Line Items in Zone Cibles

Departments	1 Year's Operating Expenses (ZCs Only) in USD	1 Year's Salary Expenses (ZCs Only) in USD	RBF Funding in USD *
Grand Anse	$550,355	$113,735	$221,668
Nippes	$574,987	$315,780	$88,477
Centre	$651,458	$432,866	$184,029
Ouest	$704,640	$496,294	$1,861,494
Sud	$368,830	$193,007	$99,666
Sud-est	$255,172	$126,635	$88,604
TOTAL	**3,105,442**	**$1,678,318**	**$2,543,938**

* RBF funding based on estimated coverage provided in the RBF budget template

The project will also work with NGO run facilities to reduce operating costs to allow for RBF incentives.

Scenario 2 Pros: Smaller reduction in operation budgets results in less risk for facilities in the event that they do not earn back 100% of the RBF budget.

Scenario 2 Issues: Additional funding will be needed to finance RBF incentive as salary expenses only account for around $1.6 million in budget reductions, a further $865,000 in budget reductions will be necessary in order to SSQH-CS to fuller cover RBF incentives. Depending on MSPP's budget and budget

cycle, the Ministry may not be able to reallocate funds to cover salary expenses or may not be able to request for additional funds to absorb ZC staff during the first few months of RBF implementation.

Scenario 3

In scenario 3 SSQH- CS would implement the full set of RBF indicators (minus the FP indicators) at a reduced unit price per indicator. The rational for this scenario is that a proportion of the current unit cost per indicator includes estimated operational cost to provide the service. Since operational cost is bore by SSQH-CS, a suggested solution is to reduce the unit price per indicator by 50 percent. Final percentage reduction to the unit cost will be determined after further discussion with MSPP, WB, LMG and MSPP.

Implementation will follow a phased approach as described in Scenario 1. The exact number of facilities to be included in Sud, Center, Quest, and Sud-Est will depend on cost analysis.

The following table presents illustrative cost analysis of reduced unit price per indicator (as suggested by MSPP/LMG). With the reduced price per indicator, facility operational budgets would only be cut by 5 percent.

Scenario 3: Key Design Element

Package: 16 quantitative indicators (excluding FP indicator per discussion with USAID) at 50% of unit price and list of qualitative indicators, adjusted for services offered at level of care.

Incentive Payment Structure:
For Disp, CSL & CAL:
- SSQH provides 95% operational cost
- Facilities have opportunity to earn up to 15% additional funding from RBF incentives (total 105%)

For Referrals and Hospitals:
- SSQH provides 100% of operational cost
- HCRs have opportunity to earn up to 1% additional funding from RBF incentives (total 101%)

Table 6: Scenario 3 - Minimum and Maximum Budgets per Facility in Grande Anse and Nippes

Facility	ZC/NGO	Primary Service Tier	1 Year's Operating expenses in USD	Minimum - Year 1	Maximum - Year 1
Grande Anse					
DDS Operating Cost			357,131.15	357,131.15	357,131.15
CS Abricots	Abricots	CSL	109,226.45	103,765.13	114,687.77
CS de Corail	Corail	CSL	83,997.34	79,797.47	88,197.20
Klinik Pèp Bondye	HHF	Dispensaire	396,631.26	376,799.70	416,462.83
Klinik St. Joseph	HHF	Dispensaire	72,965.12	69,316.86	76,613.37
CSSH	CSSH	CAL	105,825.34	100,534.08	111,116.61
CS Léon Coicou	CSLC	CAL	53,065.13	50,411.87	55,718.38
AEADMA, Dame Marie	AEADMA	HCR	270,280.61	270,280.61	272,983.42
Sub-total			**1,449,122.40**	**1,408,036.86**	**1,492,910.73**
Nippes					
DDS Operating Cost			510,246.58	510,246.58	510,246.58
CS de L'Azile	L'Azile	CAL			
Disp. Changieux	L'Azile	Dispensaire			

Disp Morisseau	L'Azile	Dispensaire			
L'Azile Total			281,579.45	267,500.48	295,658.42
CS Petit Trou de Nippes	Petit Trou de Nippes	CAL			
Disp Grand Boucan	Petit Trou de Nippes	Dispensaire			
Petit Trou de Nippes Total			281,579.45	267,500.48	295,658.42
CS Jules Fleury	Anse a Veau	CAL			
Disp. Arnaud	Anse a Veau	Dispensaire			
Disp St. Yves	Anse a Veau	Dispensaire			
Total Anse a Veau			243,262.42	231,099.29	255,425.54
Sub-total			**1,316,667.90**	**1,276,346.84**	**1,356,988.97**

Scenario 3 RBF Year 1 (October 2014 – September 2015) for Nippes & Grand Anse

- Tier 1 (Dispensary, CSL & CAL): 95% operational budget / up to 105% operational budget + RBF
- Tier 2 (Referral Hospitals/HCRs): 100% operational budget / up to 101% operational budget + RBF

Scenario 3 Pros: Smaller reduction in operation budgets results in less risk for facilities in the event that they do not earn back 100% of the RBF budget.

Scenario 3 Issues: With a reduction in financial incentive, RBF may have less anticipated impact on overall quality and quantity of services.

Summary of Scenarios

Table 7 presents a summary of the three financing scenarios and potential impact to health facilities, MSPP, and USAID. It should be noted that the following scenarios are based on the assumption that SSQH maintains the same level of funding for service delivery in Years 2 and 3. Any reduction in level of funding in service delivery will have a significant impact on RBF payment structure.

Table 7: Summary of Scenarios

	Design	Potential financial burden to Health Facilities	Potential financial burden to MSPP/DDS	Potential financial burden to USAID/ SSQH
Scenario 1	16 indicators at full unit price Full list of quality indicators	Disp/CSL/CAL: 90% operational cost Up to 15% additional revenue from RBF HCR: No impact to operational cost. Up to 1%	Limited financial burden	• Up to 5% in additional payment if all health facilities earn full RBF incentive • Potential impact in other services with a reduction in operational

		additional revenue from RBF		cost
Scenario 2	16 indicators at full unit price. Full list of quality indicators Transition ZC salary payments to MSPP/DDS	Limited financial burden	Absorb $1.6 million in salaries	• $865,000 in financing gap • Potential impact in service delivery if ZC cannot absorb additional salary
Scenario 3	16 indicators at 50% unit price Full list of quality indicators	Disp/CSL/CAL: 95% operational cost Up to 10% additional revenue from RBF HCR: No impact to operational cost. Up to 1% additional revenue from RBF	Limited financial burden	• Up to 5% in additional payment if all health facilities earn full RBF incentive

Conclusion

SSQH-CS is committed to find a balance of a faithful implementation of the MSPP's RBF scheme, adjustments of SSQH-CS activities to make implementation feasible and to moderate risk to service delivery institutions. The scenarios detailed above illustrate potential funding options for Year 1 implementation in Nippes and Grand Anse. As we work to mitigate the many challenges apparent in the implementation we also look forward the opportunity RBF provides to improve the quantity and quality of health services.

Annex B: RBF Financial Analysis

Following the two day workshop with USAID, LMG, and the SSQH projects a new scenario was proposed which would require a reduction in the operating budgets of all 80 sites in order to free funding for RBF. Under this scenario the project would implement all indicators at full price in a select number of facilities. Under this scenario sites could see a reduction in operating costs from 5% to 15%.

2 Year RBF Budget			
Number of Sites	**Total RBF Budget**	**% Reduction Needed**	**Total Savings**
39 Sites	$ 2,496,613.48	15%	$ 2,287,728.75
30 Sites	$ 1,480,909.03	10%	$ 1,525,152.50
17 Sites	$ 724,678.90	5%	$ 742,766.35

As reductions in operating budgets for RBF are taking place in at the same time as overall reductions in service delivery budgets the project chose a 10 percent reduction for RBF. Any additional reduction would be challenging for the sites to absorb. In addition to the reduction in service delivery operational expenses, the project is reviewing its activities in search of saving in programming that could be used to fund additional facilities on RBF.

Annex C: ZC Funding Mechanism Analysis Summary

Contractual Mechanisms for RBF Incentive Payments to Publically-Managed Health Facilities in Haiti

Problem Statement

In 2013, the Ministère de la Santé Publique et de la Population (MSPP), in partnership with USAID and the World Bank, designed a results-based financing (RBF) program that provides financial incentives to health facilities to increase coverage of selected health care services and to improve quality of care. On a quarterly basis, results reported by health facilities are verified by a third-party organization and incentive payments are approved by the DDS and disbursed to health facilities. The RBF national manual provides broad stroke guidelines on how the RBF incentive may be distributed within a facility (i.e., at least 30% of the RBF incentive should go towards infrastructure improvement, and/or trainings to improve quality of services, and up to 70% of the RBF incentive may be paid to staff based on performance); however each health facility has discretion over the exact allocation.

RBF incentive payments will be financed by the World Bank and USAID. For facilities supported by USAID, SSQH will manage the transfer of funds to public and NGO managed facilities. For privately-managed (NGO) facilities, current subcontracts permit the addition of RBF incentives and provide no

obstacle to implementing the MSPP scheme. However, such a subcontracting mechanism with publically-managed facilities is not an option and is in violation of the SSQH-CS contract clause stating "Contractors shall not enter into direct subcontracting relationships with GOH entities or directly pay the salaries of GOH civil servants" (AID-521-C-13-00011, pg. 10)..

To reconcile this issue, USAID has requested SSQH-CS to explore the option of issuing Fixed Obligation Grants (FOGs) as RBF payment mechanism for public health facilities. The purpose of this concept note is to explore the viability of FOGs for this purpose, as well as to consider other possible options available. It should be noted that the mechanisms discussed in this concept note are exclusively for the purpose of paying incentives under the RBF scheme; all service delivery operational costs for publically-managed facilities will continue under the current MOU mechanism.

Fixed Obligation Grants (FOGs)

A Fixed Obligation Grant (FOG) is a type of grant mechanism designed to emphasize outputs and results, limit risk, and require limited financial and management capacity. Under the FOG mechanism, fixed payments are disbursed once the recipient achieves a pre-determined program benchmark or milestone.

Two key SSQH-CS contractual issues would need to be addressed before the project could consider a FOG or any other similar mechanism for disbursing RBF incentives to publically-managed facilities. First, the project contract would have to be amended to create an exception to the clause prohibiting directly subcontracting to a GOH entity to permit RBF incentive payments. Second, USAID would have to include in the contract provisions permitting Grants Under Contract (GUCs). Both pieces should be considered before setting an action plan.

FOGs provide several advantages to facilitate the ease of payments, including the use of a fixed-price payment schedule that limits the need for substantial financial reporting[2] or audits. As such, FOG payments are commonly used to disburse funds for pre-determined, verifiable, and quantifiable activities such as training and conferences. These anticipated activities serve as milestones upon which a fixed payment is made. Less common is the use of FOG for programs with variable outputs that may not be pre-determined, such as services delivered and quality of care.

To fit within the guidelines of FOG, milestones for the RBF incentive payment would have to focus on units of services delivered, with a fixed annual amount pegged to each type. While the units of services delivered could align with the unit pricing for quantity indicators plus the percentage payment for quality indicators (up to 25% of each quantity indicator), the fixed annual amount characteristic that is a hallmark of the FOG design would be difficult to determine. The variable nature of delivering services will ultimately prevent the mechanism to operate as a fixed obligation, as the exact amount potentially available to a facility cannot be pre-determined and varies from quarter to quarter. Without a fixed obligation in place, the mechanism ceases to function as a FOG. Therefore, the project concludes that FOG may not be an appropriate mechanism for payment of RBF incentives.

Alternative Options

[2] Regardless of the funding mechanism selected, SSQH-CS will require financial reporting from the health facilities to meet project deliverables.

Given the limitations of FOGs as a payment mechanism to public facilities, SSQH – CS proposes additional options for USAID to consider. Each presents its own set of advantages and disadvantages, and potentially impacts how RBF disbursements are actualized vis-à-vis the RBF scheme as designed by MSPP. Below, we outline three options for consideration, the details of the approach and how they comply with the MSPP RBF scheme.

Option 1: Work within the MOU Agreement Framework

Description: A second option is to work within the current MOU Agreement Framework to disburse RBF incentives to publically-managed health facilities. Under the current MOU framework, SSQH-CS approves and makes direct payments for selected programmatic costs. In addition, SSQH-CS provides salary payments for 571 health facility staff in publically-managed health facilities through a fixed-term contract between staff and the project.

Using this payment structure, SSQH-CS, per guidance from DDS, will transfer RBF incentive payments to eligible employees on a quarterly basis. In addition, SSQH-CS will pay invoices for agreed-upon programmatic costs based on priorities identified in the RBF business plan. A verification and payment schedule for RBF incentive will be as described in the RBF manual.

To utilize the current MOU framework to process RBF payment, SSQH-CS will amend the MOU with participating DDS. The amended MOU will outline guidelines and procedures for two forms of payment: operation costs and RBF incentive payments. Payment procedures for operation costs will remain "as is", and payment procedure for RBF incentive will specify how the quarterly invoices will be reviewed, and processed.

Advantages: This option takes advantage of the existing payment structure and does not require adjustments to the SSQH-CS contract. Of the three options, this is the most expeditious solution to disburse RBF incentive funds to government health facilities.

Disadvantages: A key component of the MSPP designed RBF scheme is to increase financial autonomy of the health facilities. With this payment option, health facilities will not have direct access to RBF funds, as they will be disbursed directly by the project.

Option 2: ADS 303.2 Guidance Allowing USAID Contractors to Subcontract with Government Entities

Description: Pursuant to ADS 302.3.3, Contracting with a Foreign Governmental Organization, it is permissible for a USAID contractor to subcontract to local government entities. While currently unallowable under the SSQH-CS contract, this subcontracting option would permit the project to make direct cash transfers for RBF incentive payments as described in the RBF Manual. As stated above, operational expenses would continue to be paid by SSQH-CS directly through the current MOU mechanism; subcontracts would be used solely for RBF.

Advantages: The MSPP's RBF Manual uses contracts to define relationships between all entities in the RBF model. Subcontracting is the sub-award mechanism most in keeping with the spirit of the Manual and the most sustainable way to roll out results-based financing. It would permit direct cash payments, which are favored by the MSPP, allowing the facilities to manage and disburse their RBF incentives in

accordance with the Manual. Additionally, a subcontract is the most straightforward acquisition mechanism to define payments based on achievement of the quantity and quality indicators, as well as to establish a payment and invoicing schedule.

Disadvantages: Similar to Option 1, the SSQH-CS contract would require amendments to remove the restriction on direct subcontracting with GOH entities. If USAID were to amend the SSQH-CS contract to allow subcontracting with GOH entities, the project would prepare the required written justification for USAID approval.

Conclusion

Based on analysis of options, our team recommends a blended approach to disburse RBF funds to public health facilities. In particular:

- For RBF payments in 2015: Utilize existing MOU payment mechanism to disburse RBF incentives (option 1).

  Disbursement of RBF incentive payments through Option 2 will require minimal programmatic adjustments. Prior to disbursement of RBF incentives to government health facilities, the team will amend existing MOU with individual departments, and establish agreements with government health facilities on disbursement guidelines (i.e., % towards staff incentive and % towards programmatic costs).

- For RBF payments in 2016, or by an agreed-upon date: Transition RBF incentive payments from direct payment (Option 1) to subcontract (option 2) mechanism to better facilitate RBF incentive disbursement as its designed under the RBF manual.